REQUEST FOR ADDITIONAL INFORMATION
Amendments to Florida's Managed Care Waiver
To Merge Prepaid Mental Health Waiver
12-12-03
Responses From Florida Medicaid

Description of Waiver

1. **Page 11, Item A.III.b – The State indicates that the implementation date for the expansion areas will occur in State Fiscal Year 2003/2004 and 2004/2005. Since the State will be using a competitive procurement process to select the mental health contractors, please describe more specifically the State's plan and timeline for expanding.**

   Response
   Florida Medicaid does not plan to expand prepaid behavioral health care services at this time.

   The original timetable for expansion of prepaid arrangements was developed with a planned phase in process that would develop prepaid arrangements in two AHCA areas every 4 months beginning in January 2004. However, this plan has been delayed until a legal opinion is received from the Office of the Attorney General. On November 17, 2003 the Agency for Health Care Administration sent a letter to the Office of the Attorney General to request an interpretation of the requirements for capitated prepaid arrangements for behavioral health care services as set forth in Committee Substitute for Senate Bill 2404 (see copy of letter / attachment). Because of the conflicting interpretations of the law, and seeming inconsistencies within the law an impartial interpretation was requested. Specifically, the Agency is seeking formal guidance as to whether the statutory language referencing services delivered by a single entity precludes the State from contracting with multiple managed care programs for behavioral health services in accordance with section 409.912(4)(b)3, F.S.

2. **Page 6, Item A.I.c.1 – Since the expansion will not go statewide immediately, please check this item to request a waiver of statewideness.**

   Response
   See Revised page 6, item A.1.c.1.

3. **Page 6, Item A.I.c.4 – Please add the following phrase to the end of the section 1902(a)(4) description: "the State seeks a waiver of 42 CFR 438.52 on choice of plans and 42 CFR 438.56 on disenrollment."**

Response
See Revised page 6. item A.1.c.4.

~~***4.***~~ **Page 6, Item A.II – Since the program was amended in 2001 to add 14 counties, please explain why the State is currently operating in only 9 counties.**

Response
See revised page 7.

The original reasons why the 14 counties slated for prepaid in 2001 did not enter into a capitated arrangement are as follows:

- *Alachua County (1 lone county) was slated to go "prepaid" alone, leaving the remaining several counties in Area 3 in fee for service. It was not possible/feasible to isolate one county out of an entire Medicaid Area.*

- *Area 5 (Pinellas/Pasco) providers were resistant to prepaid mental health, so further education and round table discussions were necessary in order to encourage providers to respond to the RFP.*

- *Area 8 did not have any inpatient psychiatric hospitals, so calculation of cap rate based on history within the geographical area was not possible. Calculated cap rate without inpatient history would have been too low to support prepaid behavioral health.*

The original problems identified in these areas of the State are under review and will be addressed with the implementation of the RFP process for prepaid behavioral heath plans.

5. Page 13, Item A.III.d.8 – The second paragraph indicates "SOBRA" individuals are eligible. Does SOBRA here refer to just poverty level children, or to pregnant women as well? Page 14, item A.III.d.7 indicates that poverty pregnant women are excluded from PMHP.

Response
See revised page 13.

Only Medipass recipients are eligible for PMHP. Pregnant women are excluded from Medipass eligibility and, therefore, are also excluded from

PMHP enrollment. Only poverty level children are eligible from the SOBRA category.

6. **Page 7, Item A.II – In the third paragraph, the second sentence states, "The [per member per month] payment is currently 9 percent of Medicaid's anticipated cost providing mandatory covered mental health services to eligible persons residing in the project areas." Please delete this sentence as it essentially references the old upper payment limit requirements for rates, which no longer exists.**

   Response
   See revised page 7, item A.II, third paragraph.

7. **General – Other than merging the two waivers, and the changes noted on page 7-8 (add substance abuse; expand program statewide), please clarify any additional changes that the State is making from the previous waiver period?**

   Response
   Substance abuse is now excluded. The state does not plan to expand at this time. There are no additional changes to the plan that are not already included on the waiver amendment.

8. **General – In merging the waivers, will there be any duplicative services and/or costs?**

   Response
   See revised page 8.

   There will be no duplicative services or costs associated with merging the waivers.

9. **General – What programmatic or payment changes, if any, will be made by incorporating the mental health waiver into the physical health waiver?**

   Response
   See revised page 8.

   No programmatic or payment changes will be made by incorporating the mental health waiver into the physical health waiver.

10. **Page 13, Item A.III.d.2 – Are Section 1931 adults and related populations included in this program? If so, please check this item.**

    Response

Individuals eligible for Medicaid based on their eligibility for Temporary Assistance to Needy Families (TANF) are included as eligible recipients for PMHP.

Enrollment/Disenrollment

11. Page 18, Item A.IV.b – Are all HMO enrollees going to be transitioned to the PBHP? If not, please specify which HMO enrollees will continue to get mental health services through PBHP, and which through the HMO.

Response
See revised page 18.

In Medicaid Areas One and Six, recipients enrolled in an HMO do not get mental health services from the PMHP. Only Medipass recipients are eligible for PMHP.

12. Page 18, Item A.IV.b – Do enrollees of other managed care programs (EPO, CMS, PSN) currently get mental health through those entities? If so, will they be transitioned to PMHP?

Response
See revised page 18.

All Medipass recipients are enrolled in PMHP including recipients already enrolled in other managed care specialty programs such as EPO, CMS, and PSN. Mental Health services are provided through the PMHP, not through EPO, CMS, or PSN.

13. Page 19, Item A.IV.b – Please describe the notification and outreach processes that will occur for Medicaid beneficiaries about the program changes.

Response
See revised page 18.

The plan contractor is responsible for advising enrolled members of changes to service delivery and changes to the provider network. This notification process includes restrictions on provider access, additions or deletions in services offered under the plan, and any other plan modification that would have significant effect on services delivered to members.

14. Page 19, Item A.IV.b – How will beneficiaries who are currently enrolled in HMOs be notified that they will no longer receive mental

health services through their HMO's provider if this provider is not enrolled in PMHP? What will be done to assure that beneficiaries' relationship with their current mental health provider will be maintained?

Response
Not Applicable :
The State is not requesting expansion of the prepaid program at this time.

Area Six is held harmless and is, therefore, excluded from any legislative changes regarding HMOs. In Area One, it is anticipated that the HMO providers will eventually transition into the PMHP system and recipients will be allowed to continue to see their current provider for services. The PMHP contractor will be responsible for notifying recipients of any unforeseen, required provider change that occurs as a result of legislative changes.

15. **Page 22, Item A.IV.b.5 – To accurately reflect the State's requirement for mandatory enrollment into a single entity, please check item A.IV.b.5.(b), and add clarifying language that they can disenroll from a given PMHP contractor if they move out of the contractor's service area.**

Response
See revised item A.IV.b.5 on page 22.

Language is included in the PMHP contracts allowing recipients to disenroll from a given PMHP contractor if they move out of the contractor's service area.

Services

16. **Page 26, Item A.IV.d – Please specify the services that will be included for substance use disorders? For example, does it include intensive outpatient, methadone maintenance, as well as traditional inpatient and outpatient?**

Response
Substance abuse is now excluded from this waiver amendment.

17. **Page 26, Item A.IV.d – In providing substance abuse services, the community mental health center providers seem to be the primary network providers (see also page 18). Is the State expecting that they would also provide substance abuse services—which might narrow the services in SAMHSA's judgment? Please further define the substance abuse providers, as they are often not the same as mental**

health providers for services listed on page 162. In addition, please be more specific on page 34 about the staff requirements, as the statement that they will be the meet the same standards as mental health is too vague when providers may be differently trained and licensed.

Response
Under Medicaid, all substance abuse providers are enrolled as community mental health providers (type 05) for billing purposes. Differentiation from mental health providers occurs in that substance abuse providers must have a contract with the Department of Children and Families, and be licensed by the Department of Children and Families as meeting all legal requirements to provide substance abuse treatment. Substance abuse services are excluded at this time.

18. **Page 25, Item A.IV.c.3 – Please provide an assurance that when the contracts in Areas One and Six reach the end of their current contract term, that the State will reprocure through an open, competitive procurement process.**

Response
See revised page 25.

When the contracts in Medicaid Areas One & Six reach the end of their current contract term, the State will re-procure through an open, competitive procurement process.

19. **Page 28, Item A.IV.d.2(d) – Within this item, please check "(i)" and "(iii)," which are Federal requirements.**

Response
See revised items (i) and (iii) on page 28.

20. **Appendix D.2.S. – What is the specific schedule for adding substance abuse services to PMHP?**

Response
Substance abuse services are excluded from this waiver amendment.

21. **Page 43, Item B. IV.b – After item (iv), the amendment states, "Individuals targeted for enrollment in the waiver program do not include special needs population." However, on page 3 of the BBA amendment document, in section B.III, the State lists the special needs population that will be enrolled. Please clarify which statement is accurate, and conform the other statement.**

Response
See revised page 43, item B.IV.b.

PBHP covers special needs populations as defined as adults with a serious and persistent mental illness, children with special needs due to physical and/or mental illnesses, adults age 65 and older, foster care children, non-elderly adults who are disabled or chronically ill with developmental or complex physical needs.

22. **Page 45, Item B.VI.b – Please describe the care coordination activities between the MediPass Primary Car Provider (PCP) & PMHP. In addition, please describe the requirements for the coordination between the mental health and substance abuse providers for beneficiaries with dual diagnoses*.***

Response
See revised page 45.

Coordination of care activities with Primary Care Providers and for dually diagnosed individuals is a requirement of PMHP contractors to include the following:

a. Minimizing disruption to the enrollee as a result of any change in service provider or mental health targeted case manager occurring as a result of the awarding of this contract;
b. Providing appropriate referral to the enrollees' MediPass primary care case managers (or other physician, for HMO or non-MediPass enrollees) and scheduling of assistance for enrollees needing physical health care and behavioral health treatment services;
c. Documenting in clinical records all enrollee emergency encounters and appropriate follow-up;
d. Documenting all referral services in the enrollees' clinical records;
e. Monitoring enrollees with ongoing behavioral health conditions;
f. Providing direct behavioral health service providers with copies of the Medicaid Prescribed Drug Report relating to their respective plan enrollees, and coordinating, on an as needed basis, with other staff, subcontractors, or non-plan providers the provision of behavioral health-related drugs to plan enrollees;
g. The contractor shall have in place protocols for coordinating care among multiple providers;
h. When the drug report indicates that a plan enrollee being treated by a PMHP network provider is receiving an anti-psychotic medication (including atypicals) from a MediPass physician or prescribing non-psychiatrist physician, the provider shall request a consultation with the MediPass physician or prescribing non-psychiatrist physician. When the drug report indicates that a plan enrollee being treated by a PMHP network provider is receiving medications for certain

physical conditions (such as hypertension, diabetes, neurological disorders, cardiac problems, or any other serious medical condition) a consultation with the MediPass or prescribing physician shall be attempted prior to prescribing additional medications, to discuss coordination of care and concerns related to drug interactions;

i. Monitoring enrollees admitted to state mental health institutions.

j. Monitoring enrollees admitted to Children's Residential Treatment (Levels I – IV;

k. The contractor shall provide a quarterly report related to the follow-up of children placed in residential treatment;

l. The contractor shall coordinate care with the Department of Children and Families, Family Safety Office for children in care and custody of the department who are admitted to residential treatment facilities;

m. Coordinating hospital and/or institutional discharge planning for psychiatric admissions including appropriate post-discharge care;

n. Providing referral of the enrollee for non-covered services to the appropriate service setting, and requesting referral assistance, as needed, from the Area Medicaid Office;

o. Entering, prior to commencement of services, into agreements with agencies funded pursuant to Chapter 394, Part IV, F.S., that will not be a part of the plan's provider network, regarding coordination of care and treatment of enrollees jointly or sequentially served. These agreements shall be approved by the agency;

p. Providing court ordered behavioral health evaluations for its enrollees as required by and within the time limits specified by the courts; and

q. *Providing appropriate screening, assessment, crisis intervention and support for enrollees who are in the care and custody of the state.*

In the event of a disagreement between the agency and the contractor regarding the appropriate treatment of an enrollee who has been referred to the contractor's provider, the decision of the agency shall prevail. The plan enrollee may appeal decisions through the fair hearing process established by the department. (Please refer to Section 2.15 for grievance procedures.) This protocol shall be included in all subcontracts implemented to carry out the prepaid mental health plan contract.

Provider Network Capacity

23. Page 40, Item B.III.c. – What happens if there is no mental health contractor in a certain area of the state? How will mental health services be delivered?

Response

Not Applicable:
The State is not requesting expansion of the prepaid program at this time.

Cost Effectiveness

24. What are major services that fall under "other" category ($124 million)?

Response
"Other" services include everything not included in the other categories such as hospice, home health, therapies (other than behavioral health such as speech and occupational) rural health clinics, FQHCs, EPSDT screens, dental, vision and hearing services, transportation, waiver services, case management, personal care, private duty nursing and nursing home or other institutional care.

25. The State has provided an attachment with data on cost effectiveness of the PMHP over the past waiver period. As part of this amendment, please project the with and without waiver PMPM for existing Areas One and Six for the next year (through September, 2004, the end of the Medicaid Managed Care Waiver term). In addition, please estimate the PMPM with and without the waiver for the additional Areas that will be added through September, 2004.

Response
No additional areas will be added at this time.

TABLE 2-Per Member Per month Costs for Mental Health Area 6 and 1. Actual and Estimated With Waiver and Without Waiver Costs In last Mental Health Waiver.

	Projected with waiver FY 2001-02**	Actual FY 2001-02	Projected without waiver FY 2001-02**	Projected with waiver FY 2002-03**	Actual with waiver FY 2002-03	Projected without waiver FY 2002-03**	Projected with waiver FY 2003-04	Projected without waiver FY 2003-04
AREA 1 PMPM	$20.25	$20.58*	$21.02	$20.52	$21.90	$21.75	$22.38	$23.57
AREA 6-PMPM	$25.51	$26.00	$29.64	$26.39	$23.74	$30.29	$24.04	$29.10

**In the time period after implementation of managed care the PMPM was $19.93. ** Projections done by Mercer for last waiver*

Note that actual costs are slightly different for FY 2002-03 than in the prior submission as the earlier actual was prior to the year being closed out. We have added information for estimates for the FY 2003-04.

Projected with waiver PMPM for FY 2003-04 are based on using the new cap rate and caseloads as of April 2003. Summary sheets are in Attachment 1.

Projected without waiver costs for FY 2003-04 are based on the following methodology. Mercer did the projected without waiver costs for FY 2002-03. However, they overestimated actual with waiver costs in Area six for FY 2002-03. Area 1 was as expected. The difference between actual and projected waiver costs was subtracted from the without waiver PMPM calculated by Mercer for FY 2002-03. The result and Mercer projection for without waiver costs in one were projected forward on the expected medical price increase of 5.3 percent for FY 2003-04.

Using the April 2003 case loads, costs with and without the waiver are presented in Table 2A below:

Table 2A- Estimated Savings with Waiver for FY 2003-04

	Costs without waiver FY 2003-04	Costs with Waiver FY 2003-04	Savings FY 2004-04
Area 1	$1,636,256	$1,350,265	$285,991
Area 6	$ 806,165	$ 765,602	$ 40,563
Total	$2,442,421	$2,115,867	$326,554

26. Administrative costs – Will there be a projected increase in administrative costs due to expansion of the program statewide? If so, please provide details.

Response

Not Applicable:
The State is not requesting expansion of the prepaid program at this time.

27. Addition of substance abuse – What are the additional costs on a PMPM basis?

Response
Substance abuse is now excluded from this waiver amendment.

Grievance

28. Page 144, Item G.II.a.4 – This is a Federal requirement. Please check it, and specify the timeframe used by the state.

Response
See revised page 144, item G.II.a.4.

The definition of grievance in the RFP is precisely the Federal definition. Grievances are to be resolved in a specified timeframe, not to exceed thirty (30) days from the initial filing by the member or provider, unless information must be collected from providers located outside the authorized service area or from non-contract providers. In such exceptions, an additional thirty-day extension is authorized.

Enrollee Information

29. Page 148, Item H.II – Since Medicaid recipients are automatically enrolled, there is no point in time when a recipient would be a potential enrollee. As a result, the State should remove the "X" from item "a."

Response
See revised item H.II.a on page 148.

30. **Page 151, Item H.III.c – The information in this section is required by Federal regulation. Please check items (iv), (xvi), and (xvii).**

Response
See revised items H.III.c(iv), (xvi), and (xvii) on page 151.

Funding Source

31. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid covered services for Medicaid eligible individuals, we are asking states to confirm to CMS that the PIHPs in the Prepaid Mental Health Plan (PMHP) retains 100 percent of the payments. Does the PIHP retain all of the Medicaid capitation payments? Does the entity participate in such activities as intergovernmental transfers or certified public expenditure payments, including the Federal and State share, or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization? If the PIHP is required to return any portion of any payment please provide a full description of the repayment process.

Include in your response a full description of the methodology for the return of any of the payments, a complete listing of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).

Response

The PMHP contractor is required to accept the capitation payment received each month as payment in full by the Agency for all services provided to enrollees covered under the plan and the administrative costs incurred by the contractor in providing or arranging for such services. Any and all costs incurred by the contractor in excess of the capitation payment will be borne in total by the contractor. There will be no additional payment to cover any "start up" or "phase down" costs to the contractor. The contractor is responsible for Social Security and income tax withholdings. The state share of the Medicaid payment for the PMHP contractor is funded through legislative appropriations. The PMHP contractors retain all Medicaid payments and do not participate in such activities as intergovernmental transfers or certified public expenditure payments, including the Federal and State share, nor is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization. The PMHP contractor must agree to return to the Agency any overpayments due or funds disallowed pursuant to the terms of the plan contract.

The repayment process is initiated by the state upon discovery that a capitation payment has been made in error to the PMHP contractor. Capitation payments are recouped when a recipient's Prepaid Mental Health Plan coverage did not end in a timely manner due to various reasons (e.g.: a member's death or a member moving out of the PMHP contractor's coverage area). Between 1999 – 2003, the PMHP contractor in Medicaid Area 6 has returned on average 0.45% of their capitation payment; and, between 2002 – 2003, the PMHP contractor in Medicaid Area1 has returned on average 0.04% of their capitation payment. Both PMHP contractors are averaging less then 1% of their capitation payments being returned to the general fund.

PMHP expenditures are reported quarterly to CMS on the CMS-64 form.

32. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of the Medicaid capitation payment for the PIHP is funded. Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public

expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditures and State share amounts for the Medicaid capitation payment. If any of the state share is being provided through the use of local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the state verifies that the expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).

Response
The entire state share is provided through General Revenue appropriation.

33. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to the PIHP.

Response
No supplemental payments are made for behavioral health services included in this amendment.

34. Are there any actual or potential payments to the PIHPs under this waiver which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (these payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.) If so, how do these arrangements comply with the limits on payments in 438.6(c)(5) and 438.60 of the regulations?

Response
There are no risk corridors or other similar payments associated with PMHP or HMOs.

35. **If managed care contracts include mechanisms such as risk corridors, does the state recoup appropriate amount of any profits and return the Federal share of the excess to CMS on the quarterly expenditure reports*?***

Response
Florida does not have risk corridors in their contracts.

Attachment 1.

Prepaid Mental Health Rate Settings Comparison (FY 02/03 vs. FY 03/04) for Area I
Substance Abuse Out

		FY 03/04			FY 02/03				
		Case Load	Rate	Amount	Case Load	Rate	Amount	DIFF	% DIFF
0-11 mos	SSI	41	$0.16	$6.56	41	$0.16	$6.56	$0.00	0.00%
	AFDC	947	$0.02	$18.94	947	$0.02	$20.83	$0.00	-9.09%
	FC	29	$0.06	$1.74	29	$0.06	$1.74	$0.00	0.00%
	OBRA	629	$0.01	$6.29	629	$0.01	$6.29	$0.00	0.00%
1-5	SSI	347	$8.07	$2,800.29	347	$7.57	$2,628.18	$0.50	6.55%
	AFDC	4177	$0.91	$3,801.07	4177	$0.90	$3,771.83	$0.01	0.78%
	FC	215	$19.91	$4,280.65	215	$15.49	$3,331.00	$4.42	28.51%
	OBRA	4216	$0.56	$2,360.96	4216	$0.52	$2,196.54	$0.04	7.49%
6-13	SSI	993	$88.14	$87,523.02	993	$86.97	$86,359.22	$1.17	1.35%
	AFDC	4471	$10.30	$46,051.30	4471	$10.73	$47,969.36	-$0.43	-4.00%
	FC	357	$73.46	$26,225.22	357	$77.54	$27,681.78	-$4.08	-5.26%
	OBRA	4066	$5.56	$22,606.96	4066	$6.09	$24,745.68	-$0.53	-8.64%
14-20	SSI	812	$86.54	$70,270.48	812	$86.60	$70,320.01	-$0.06	-0.07%
	AFDC	2134	$12.06	$25,736.04	2134	$10.97	$23,405.71	$1.09	9.96%
	FC	224	$53.62	$12,010.88	224	$51.19	$11,466.56	$2.43	4.75%
	OBRA	1784	$10.07	$17,964.88	1784	$11.11	$19,816.67	-$1.04	-9.34%
21-54	SSI	3355	$105.87	$355,193.85	3355	$102.05	$342,367.69	$3.82	3.75%
	AFDC	4052	$7.74	$31,362.48	4052	$7.10	$28,773.25	$0.64	9.00%
55+	SSI	1317	$42.89	$56,486.13	1317	$40.99	$53,978.56	$1.90	4.65%
	AFDC	37	$24.19	$895.03	37	$6.52	$241.28	$17.67	270.96%
Total		**34,203**	**550.14**	**$765,602.77**	**34,203**	**522.59**	**$749,088.74**		
Average				**$22.38**			**$21.90**		
Difference				**2.20%**					

Note: April 2003 Case Load Used

Prepaid Mental Health Rate Settings Comparison (FY 02/03 vs. FY 03/04) for Area VI (use D4 actuals)
Substance Abuse Out

		FY 03/04			FY 02/03				
		Case Load	Rate	Amount	Case Load	Rate	Amount	DIFF	% DIFF
0-11 mos	SSI	102	$1.54	$157.08	102	$1.54	$157.08	$0.00	0.00%
	AFDC	2058	$0.01	$20.58	2058	$0.02	$39.10	-$0.01	-47.37%
	FC	82	$0.01	$0.82	82	$0.01	$0.98	$0.00	-16.67%
	OBRA	1062	$0.01	$10.62	1062	$0.01	$10.62	$0.00	0.00%

1-5	**SSI**	1085	$17.00	$18,445.00	1085	$19.16	$20,786.43	-$2.16	-11.26%
	AFDC	6211	$2.38	$14,782.18	6211	$2.49	$15,452.97	-$0.11	-4.34%
	FC	800	$25.19	$20,152.00	800	$25.47	$20,379.20	-$0.28	-1.11%
	OBRA	5907	$1.14	$6,733.98	5907	$1.08	$6,385.47	$0.06	5.46%
6-13	**SSI**	2697	$96.81	$261,096.57	2697	$94.90	$255,939.91	$1.91	2.01%
	AFDC	6802	$14.06	$95,636.12	6802	$13.77	$93,636.33	$0.29	2.14%
	FC	1472	$100.54	$147,994.88	1472	$107.78	$158,646.27	-$7.24	-6.71%
	OBRA	5297	$8.71	$46,136.87	5297	$8.33	$44,139.90	$0.38	4.52%
14-20	**SSI**	1982	$50.40	$99,892.80	1982	$51.20	$101,484.35	-$0.80	-1.57%
	AFDC	3242	$10.52	$34,105.84	3242	$9.30	$30,163.57	$1.22	13.07%
	FC	827	$79.95	$66,118.65	827	$92.57	$76,552.91	-$12.62	-13.63%
	OBRA	2199	$6.99	$15,371.01	2199	$6.65	$14,618.95	$0.34	5.14%
21-54	**SSI**	5376	$70.89	$381,104.64	5376	$66.90	$359,654.40	$3.99	5.96%
	AFDC	5303	$4.54	$24,075.62	5303	$4.67	$24,765.01	-$0.13	-2.78%
55+	**SSI**	3555	$33.14	$117,812.70	3555	$30.79	$109,465.56	$2.35	7.63%
	AFDC	101	$6.11	$617.11	101	$9.32	$941.12	-$3.21	-34.43%
Total		**56,160**	**$529.94**	**$1,350,265.07**	**56,160**	**$545.96**	**$1,333,220.13**		
Average				**$24.04**			**$23.74**		
Difference				**1.28%**					

Note: April 2003 Case Load Used